Callahan Eye Clinic, PC

Patient Name: _____ Date: _____

Patient Signature: _____

Please check any of the following regarding how your eyelid(s) bother you and are affecting your general lifestyle functions:

- ☐ My lids are itchy.
- ☐ My vision is impaired to the side(s).
- ☐ I must hold up my lids with my fingers to see.
- ☐ I must hold my head upward when trying to read, watch television, or use a computer.
- ☐ My lids feel heavy.
- ☐ I find it hard to open my eye(s).
- ☐ Other (Please describe below.)

_____

_____

_____

Submit Form